Letter to Providers

MEMORANDUM
September 2010

To: All Providers of Community Support Team, Day Treatment, Intensive In-Home, and Community Support

Subject: CABHA Transition Action Letter

Please read this letter carefully as it contains important information that may affect your agency and your consumers.

As you are aware, North Carolina continues to undergo changes to our service delivery system which will impact Medicaid, IPRS, and NC Health Choice consumers. These changes include the new Critical Access Behavioral Health Agency (CABHA) qualifications for providers of Intensive In-Home (IIH), Day Treatment (DT), and Community Support Team (CST) services, the ending of Community Support (CS) services, and the new Mental Health/Substance Abuse Targeted Case Management (MH/SA TCM) service. For more detailed information on CABHAs, visit http://www.ncdhhs.gov/mhddsas/cabha/index.htm.

While most providers currently providing services may continue service delivery until December 31, 2010, it is critically important that all providers understand the benchmarks established so that consumers receiving CS, CST, DT and IIH services from non-CABHA certified agencies experience a timely and seamless transition to CABHA certified agencies or other basic outpatient services. P**roviders are expected to become CABHA certified or establish transition plans for consumers to certified CABHA agencies according to the benchmarks identified in Special IU #79 and reiterated herein.**

In order to ensure appropriate consumer transitions from agencies that do not attain CABHA certification, the Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Service (DMH/DD/SAS) will disseminate tracking information to the Local Management Entities (LMEs) and utilization review vendors which identifies which providers are in compliance with the benchmarks. **Failure to submit an appropriate transition plan shall result in suspension of payment.**

Benchmarks
To facilitate a smooth transition for recipients from providers who will not meet CABHA certification by January 1, 2011, the following benchmarks have been established in consultation with the Centers for Medicare and Medicaid Services (CMS). Benchmarks will apply to Medicaid, State-funded, and Health Choice consumers:

- As stated previously in Implementation Update #75, complete attestation packets and applications for CABHA certification must have been submitted to DMH/DD/SAS on or before August 31, 2010 in order to ensure that the certification and enrollment process would be completed on or before December 31, 2010. Attestation packets will continue to be accepted after August 31, 2010 but the Department of Health and Human Services (DHHS) cannot guarantee that the certification and enrollment process will be completed by December 31, 2010 in such cases.
- Upon receiving CABHA certification, providers must submit a complete, accurate Medicaid Provider Enrollment application to enroll as a CABHA, available on www.nctracks.nc.gov, in order for the Medicaid enrollment process to be completed before December 31, 2010. Applications that are returned as incomplete may result in a delay of the CABHA Medicaid Provider Number (MPN) assignment. At that time, CABHAs may also enroll for a statewide MH/SA TCM MPN.
- **Transition Plan Benchmarks**
  - **Providers who are not planning on becoming CABHAs and providers who have not successfully passed the Desk Review on or before September 30, 2010 must submit a complete Transition Plan (see requirements below) for Medicaid and State-funded**

consumers to the LME responsible for monitoring the provider by October 15, 2010 for consumers who will need continued CST, IIH, DT or who will need to be transitioned to MH/SA TCM services from CS services. Providers for Health Choice consumers must send a completed "NC Health Choice Consumer Discharge/Transition Plan" (see attached) for each Health Choice consumer who will need continued IIH or DT services or who will need to be transitioned to MH/SA TCM services from CS services to ValueOptions at the Health Choice fax at 1-977-339-8758.

- **Providers who have not successfully passed the Interview and Verification process by October 31, 2010 must submit a complete Transition Plan (see requirements below) for Medicaid and IPRS recipients to the LME responsible for monitoring the provider by November 15, 2010 for consumers who will need continued CST, IIH, DT or who will need to be transitioned to MH/SA TCM services from CS services. Providers for Health Choice consumers must send a completed "NC Health Choice Consumer Discharge/Transition Plan" (see attached) for each Health Choice consumer who will need continued IIH or DT services or who will need to be transitioned to MH/SA TCM services from CS services to ValueOptions at the Health Choice fax at 1-877-339-8758.**

- **Authorization Benchmarks**
  - Intensive In-Home and Day Treatment providers who have not successfully passed the Desk Review on or before September 30, 2010 will no longer have any initial or concurrent authorizations approved for IIH or DT after November 1, 2010. ValueOptions, The Durham Center, or Eastpointe will return all of these requests as "Unable to Process."
  - Community Support service providers who have not successfully passed the Desk Review on or before September 30, 2010 will no longer have any initial or concurrent authorizations approved for CS after November 1, 2010. ValueOptions will return all of these requests as "Unable to Process."
  - Community Support service providers who have not successfully passed the Interview and Verification process by October 31, 2010 will no longer have any initial or concurrent authorizations approved for CS after December 1, 2010. ValueOptions will return all of these requests as "Unable to Process."

Failure to submit transition plans to the LMEs (for Medicaid and State-funded consumers) or "NC Health Choice Consumer Discharge/Transition Plans" to ValueOptions (for Health Choice consumers) by the above deadlines shall result in suspension of payment.

Transition Plan Requirements for Medicaid and State-funded Recipients

Complete Transition Plans must be submitted to and approved by the LME responsible for monitoring the provider. Contact the LME CABHA Point of Contact to determine who within your LME will receive the plan. A list of CABHA Points of Contact can be found at http://www.ncdhhs.gov/mhddsas/cabha/index.htm Complete Transition Plans include the following:

- An individual "Medicaid/State-funded Consumer Discharge/Transition Plan" (see attached) for each consumer that will be transitioned.
- An agency-wide "Transition Spreadsheet" that lists all consumers that will be transitioned (see attached). All fields on this form must be filled out for each consumer.

For Medicaid, State-funded, and Health Choice Recipients

- The provider must provide choice of available CABHAs as part of the transition process. Providers should contact their LME to obtain a list of CABHA certified providers in their catchment area or view the list of CABHA providers at http://www.ncdhhs.gov/mhddsas/cabha/index.htm.
- The provider is responsible for providing copies (with release of information form signed by the consumer or guardian) of the consumer's most recent Comprehensive Clinical Assessment (CCA) and Person Centered Plan (PCP) to the receiving CABHA provider.

- The provider agency is responsible for record retention in line with state and federal requirements. NC Medicaid providers are required to retain all records to support the billing of services for a minimum of six years from the date of service, regardless of whether the provider remains enrolled in the NC Medicaid program. **Abandonment of medical records may result in fines and/or criminal prosecution.**

Transition Plan Review Process

Failure to submit complete Transition Plans to the LMEs (for Medicaid and State-funded recipients) or "NC Health Choice Consumer Discharge/Transition Plans" to ValueOptions (for Health Choice recipients) by the above deadlines shall result in suspension of payment.

For Medicaid and State-funded Recipients

For Medicaid and State-Funded Recipients, the LME will review complete Transition Plans. If the plan is approved, the LME will communicate that to the provider and transition may begin. If the Transition Plan is not initially approved by the LME, the LME will consult DHHS, and DHHS will either affirm the LMEs decision denying the plan, or accept the Plan. If the Plan is approved after consultation with DHHS, the LME will communicate the approval to the provider and transition may begin. If the Plan is not approved, the LME will write a transition plan for the provider, and transition may begin. If the plan is not followed, there will be a suspension of payment.

Providers are reminded that failure to submit a transition plan meeting the above requirements shall result in termination of the Medicaid Provider Agreement.

It is recommended that providers monitor the North Carolina DMA and DMH/DD/SAS websites to stay informed concerning changes so that you may better advise your consumers and staff about transition requirements.

We look forward to working with you to assure a smooth transition for consumers in your care. Please contact your LME if you need additional information.